Women/Maternal Health

State Action Plan Table (Iowa) - Women/Maternal Health - Entry 1
Priority Need
Access to care for the MCH population
NPM
NPM 1 - Percent of women with a past year preventive medical visit
Objectives
By year 2020, the percent of women with a past year preventative visit will increase to 73.5%
Strategies
Increase health insurance access to women
Ensure all Title V Maternal Health clients receive post-partum follow up
Collaborate with Iowa Medicaid to improve the post-partum visit rate and the quality of visit for members
Collaborate with Medicaid Managed Care Organizations in the state to increase percent of women with a past year preventative visit
Public Health surveillance and data analysis of PRAMS, Barriers to Prenatal Care, birth certificate, and Medicaid claims data to monitor preconception health and birth outcomes.
NOMs
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations
NOM 3 - Maternal mortality rate per 100,000 live births
NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)
NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)
NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)
NOM 5.1 - Percent of preterm births (<37 weeks)
NOM 5.2 - Percent of early preterm births (<34 weeks)
NOM 5.3 - Percent of late preterm births (34-36 weeks)
NOM 6 - Percent of early term births (37, 38 weeks)
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths
NOM 9.1 - Infant mortality rate per 1,000 live births
NOM 9.2 - Neonatal mortality rate per 1,000 live births
NOM 9.3 - Post neonatal mortality rate per 1,000 live births
NOM 9.4 - Preterm-related mortality rate per 100,000 live births

Perinatal/Infant Health

State Action Plan Table (Iowa) - Perinatal/Infant Health - Entry 1
Priority Need
Breastfeeding support
NPM
NPM 4 - A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months
Objectives
By 2020, the percent of infants who are ever breastfed will increase to 85%
By 2020, the percent of infants breastfed exclusively through 6 months will increase to 21.4%
Strategies
Educate pregnant women on benefits and methods of breastfeeding
Discharge planning for ongoing breastfeeding support
Promote breastfeeding education to maternal health nursing staff
Establish links among birthing hospitals and community breastfeeding support networks in Iowa
NOMs
NOM 9.3 - Post neonatal mortality rate per 1,000 live births
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Child Health

State Action Plan Table (Iowa) - Child Health - Entry 1
Priority Need
Developmental screening and surveillance
NPM
NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool
Objectives
By 2020, the percent of children receiving a developmental screening using a parent-completed screening tool will increase to 39.3%.
Strategies
Promote parent and caregiver awareness of developmental screening
Work with provider champions in associations of health professionals to promote developmental screenings within clinical settings.
Support retaining reimbursement for developmental screening among newly established Medicaid managed care organizations
Local 1st Five sites will engage at least one primary care practice in each county of the service delivery area
Local 1st Five sites will promote increasing developmental screening in engaged 1st Five practices
Maintain requirements for the provision of developmental screening in Title V contract agencies
Promote collaboration between Title V, Early Childhood Comprehensive Systems grant, early care and education, and home visiting providers on the provision of developmental screens
NOMs
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)
NOM 19 - Percent of children in excellent or very good health

State Action Plan Table (Iowa) - Child Health - Entry 2

Priority Need

Access to quality child care

Objectives

By 2021, increase the percent of early care and education programs that receive Child Care Nurse Consultant services to 55%.

Strategies

Outreach to local early care and education programs regarding CCNC services

Encourage partnerships to support CCNC services in under-served areas of the state

Utilize local CCNCs to provide CCDBG Health and Safety pre-service/orientation training for child care providers

Promote the use of CCNC services to assist child care providers with required CCDBG Emergency Preparedness Plan requirement

Utilize the state and regional structure of Healthy Child Care Iowa's technical assistance team to support the local CCNCs

In the revised Quality Rating System require CCNC services be utilized to be designated level 3, 4, or 5

Pursue activities to provide consistent funding for CCNC services statewide

State Action Plan Table (Iowa) - Child Health - Entry 3

Priority Need

Dental delivery strategies for MCH population

Objectives

By 2021, increase the percent of children with a payment source for dental care to 91%

Strategies

Maintain and enrich partnerships with Medicaid and hawk-I dental carriers

Provide care coordination services

Conduct outreach to schools and dental offices

Utilize presumptive eligibility to assist children with dental coverage

Adolescent Health

State Action Plan Table (Iowa) - Adolescent Health - Entry 1
Priority Need
Adolescent health systems coordination
NPM
NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.
Objectives
By 2020, the percent of adolescents with preventive services in the last year will increase to 86.5%.
Strategies
Work with local primary care practitioners and other providers serving adolescents to increase the numbers served and enhance the quality of the visit.
Communicate with and share resources with school nurses statewide to promote adolescent well visits.
Partner with adolescent serving organizations or agencies, including but not limited to family planning, substance abuse, youth serving organizations, and/or community colleges to promote adolescent well visits.
NOMs
NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000
NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000
NOM 18 - Percent of children with a mental/behavioral condition who receive treatment or counseling
NOM 19 - Percent of children in excellent or very good health
NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)
NOM 22.2 - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

State Action Plan Table (Iowa) - Adolescent Health - Entry 2

Priority Need

Adolescent health systems coordination

NPM

NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Objectives

By 2020, the percent of adolescents, ages 12-17, who are bullied will decrease to 14%.

Strategies

Research and implement evidence-based program implementation models and/or curriculum.

Engage in relationship building and coordination at the state level

Obtain information about the current bullying prevention efforts being implemented in the state through schools and community-based organizations

NOMs

NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000

NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000

State Action Plan Table (Iowa) - Adolescent Health - Entry 3

Priority Need

Physical activity for MCH population

Objectives

By 2021, 89.1% of adults 18-24 will report being physically active.

Strategies

Screen for physical activity at local MCAH agencies

Partner with the Iowa Department of Education to identify existing initiatives and programs for this population related to physical health

Address physical activity for young adults within the IDPH Adolescent Health Collaborative

Collaborate with the Healthiest State Initiative to promote wellness activities

Children with Special Health Care Needs

State Action Plan Table (Iowa) - Children with Special Health Care Needs - Entry 1
Priority Need
Transition planning for CYSHCN
NPM
NPM 12 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care
Objectives
By 2020, 60% of youth with special health care needs (YSHCN) served by the Division of Child and Community Health (DCCH) Regional Centers will have a transition readiness assessment and comprehensive plan of care, including a medical summary and emergency care plan beginning by age 14.
By 2020, develop an overall state plan to coordinate transition efforts being conducted for YSHCN by various state agencies
By 2020, create a comprehensive, regionally-based resource directory of transition services for YSHCN
By 2020, increase the percent of primary care providers (PCPs) who have knowledge of transition tools for YSHCN and how to use them.
By 2020, increase the percent of YSHCN who receive assistance from their PCPs in transition planning, making positive choices about health, and gaining skills to manage health.
Strategies
Determine how many YSHCN received direct services in DCCH Regional Centers in FY 2014
In collaboration with youth and families, identify transition tools that appeal to youth and families of all cultures and align with recommendations from the American Academy of Pediatrics (AAP), the Lucile Packard Standards and Got Transition
Conduct an assessment of current efforts regarding transition to adulthood planning in Iowa for YSHCN
Form a taskforce and collaborate with the University of Iowa's electronic medical record team to assure entry of transition information and metrics for YSHCN served by UI transition programs. Use transition data from electronic medical records to populate a transition registry
Document transition resources available for YSHCN in their communities in the web portal created through the Systems Integration Grant (SIG) and Regional Autism Assistance Program (RAP), including resources for shared decision making, self-advocacy, and the inclusion of health in specialized education plans
Use social media channels to share transition information with youth, families, PCPs, educators, and agencies
Through the Iowa Chapter of the AAP, and Iowa Primary Care Association, and the Iowa Association of Nurse Practitioners, DCCH will provide ongoing technical assistance for all DCCH care coordination staff and external providers in how to use transition tools and their relation to life course theory
Develop protocol for schools/Area Education Agencies, medical specialty providers, and PCPs to refer youth with complex health care needs to DCCH for transition planning, using telehealth where needed
NOMs
NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system
NOM 19 - Percent of children in excellent or very good health

State Action Plan Table (Iowa) - Children with Special Health Care Needs - Entry 2

Priority Need

Care coordination for CYSHCN

NPM

NPM 11 - Percent of children with and without special health care needs having a medical home

Objectives

By 2020, increase the percent of families of CYSHCN who report having a comprehensive, universal plan of care that has been developed with the family and care team and is shared with all members of the care team.

By 2020, increase the number of care coordinators serving CYSHCN who receive trainings about the Shared Plan of Care.

By 2020, increase the percentage of primary care providers who provide preventive health assessments to CYSHCN, in accordance with Bright Futures.

By 2020, increase the number of health care and community providers who have information about and provide referrals for CYSHCN and their families to comprehensive home and community-based supports.

By 2020, increase the percentage of primary care providers who use shared decision making principles

Strategies

In collaboration with family representatives, provide feedback on a Shared Plan of Care template that can be used by multiple systems and programs

Define the entities involved in a Shared Plan of Care and educate those entities about the definition and importance of a Shared Plan of Care

Disseminate Shared Plan of Care template to defined entities and provide Shared Plan of Care training to families and other stakeholders of CYSHCN

Develop tools and trainings that will inform providers, staff and families of CYSHCN on the importance of the Shared Plan of Care and how to use it, assuring that families receive coordinated, family-centered care that is documented. This would include providing information on how to refer CYSHCN to relevant care coordinators and other resources in their communities

Provide trainings to families on coordinated, family-centered care

Develop or select a tool that increases provider's, teacher's and family's knowledge on shared decision making practices. Knowledge of shared decision making practices will enhance and promote the use of the Shared Plan of Care

Offer instruction to PCPs and their staff on how to provide evidence based screening tools, in accordance with Bright Futures guidelines

Work with public and private health insurance plans to incentivize delivery of Bright Future screening assessments

Continue to collaborate with Iowa's 1st Five Healthy Mental Development, Regional Autism Assistance Program's strategic planning committee, EPSDT and any additional programs that support the use of evidence based preventative health assessments and screening tools

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

NOM 19 - Percent of children in excellent or very good health

NOM 22.1 - Percent of children ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)

NOM 22.2 - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

State Action Plan Table (Iowa) - Children with Special Health Care Needs - Entry 3

Priority Need

Integration of services for CYSHCN

Objectives

By 2021, increase the percent of CYSHCN who meet the criteria for Quality of Care to 61%

Strategies

Develop and implement protocols for the utilization of a Shared Plan of Care to improve coordination of care for children and youth with special health care needs

Develop a web-based portal that provides current and well-vetted information to improve the care and outcomes of CYSHCN and their families

Support increased use of telehealth, consultative models, and other electronic communications to enhance access to pediatric specialty care and ancillary services for CYSHCN particularly for children living in rural Iowa

Cross-Cutting/Life Course

State Action Plan Table (Iowa) - Cross-Cutting/Life Course - Entry 1
Priority Need
Dental delivery strategies for MCH population
NPM
NPM 13 - A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year
Objectives
By 2020, the percent of women who had a dental visit during pregnancy will increase to 60%
By 2020, the percent of children, ages 1-17 who had a preventive dental visit in the past year will increase to 87%.
Strategies
Provide targeted outreach for medical-dental integration
Inform, educate, and disseminate scientific evidence about importance of prenatal dental screening and treatment
Assure statewide care coordination network that includes dental home referral, tracking, and follow-up for children
Expand preventive school-based sealant programs
NOMs
NOM 14 - Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months
NOM 19 - Percent of children in excellent or very good health

State Action Plan Table (Iowa) - Cross-Cutting/Life Course - Entry 2
Priority Need
Access to care for the MCH population
Objectives
By 2021, increase the percent of children 0-21 who report a medical home to 95%.
By 2021, increase the percent of women who report a medical home to 91.5%
Strategies
Monitor medical home data
Assess medical home status of children and adolescents, educate regarding its importance, and refer to medical homes
Assist families with health insurance literacy
Promote public-private partnerships with local health care providers
Establish partnerships with school nurses to promote adolescent well visits with an established provider
Meet with the Iowa Medicaid Enterprise and Medicaid Managed Care Organizations to discuss medical home, EPSDT services, and population health strategies
Explore partnerships with health care provider workforce incentive programs to increase access to care
Work with Child Health Specialty Clinics regarding promotion of medical homes for children with special health care needs
Presumptive eligibility determination for pregnant women will be done with any client who does not have insurance
Identify local resource for prenatal care for low income women and non-citizens without insurance